

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04942

1. PLACE OF DEATH: COUNTY <u>Pinel Clinic, Howard Co</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pinel Clinic</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>5602 Clear Spring Rd.</u> COUNTY <u>Balto.</u> Md. CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>12, Md.</u> STREET ADDRESS (If rural, give location) <u>5602 Clear Spring Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Maude</u>	(Middle)	(Last) <u>Bailey</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>July 12, '81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Hickory, Pa.</u>	9. AGE last birthday <u>69</u> yrs.
13. FATHER'S NAME <u>John MARSHALL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>MARY AGNES HILL</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Daughter-Mrs. C.B. Russell</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Thrombosis</u>	<u>2 days</u>
Antecedent cause(s) (b) <u>Cerebral Arterio-sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>2 years</u>
(c) <u>Depression</u>	<u>1 year</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 1, 1951, to May 9, 1951, that I last saw the deceased alive on May 9, 1951, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

SIGNATURE Living Taylor M.D. (Degree or title) ADDRESS 5-9-51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>5-12-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Scottdale</u>	LOCATION (City, town, or county) (State) <u>Scottdale, PA.</u>
DATE REC'D BY LOCAL REG. <u>5/10/51</u>	REGISTRAR'S SIGNATURE <u>W.D. Hedrick</u>	FUNERAL DIRECTOR <u>John O. Mitchell Sons 1900 Eutaw Pl.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04943

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH- COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u> TOWN <u>Simpsonville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u> TOWN <u>Simpsonville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Herbert M. Brown</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>5-25-51</u> 19 <u>51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 4, 1881</u>	9. AGE last birthday <u>69</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u>	
13. FATHER'S NAME <u>Richard H. Brown</u>		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Grace S. Brown, Simpsonville, Md.</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>					<u>Immediate</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio-Vascular Disease</u>					<u>3 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 10, 1946</u> , to <u>May 25, 1951</u> , that I last saw the deceased alive on <u>May 14, 1951</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>William F. Lassaray</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Ellicott City, Md.</u> DATE SIGNED <u>5/25/51</u>	
23. BURIAL CREMATION (Specify) <u>CREMATION</u>		DATE THEREOF <u>5-26-51</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>5-29-51</u>		REGISTRAR'S SIGNATURE <u>Mari G. Whitaker</u>		24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105

RECEIVED
JUN 4 1961
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04944

Reg. Dist. No. 192

1. PLACE OF DEATH- COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sykesville (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cockeysville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route #32		STREET ADDRESS (If rural, give location) MASONIC HOME	
3. NAME OF DECEASED (Type or Print) ALBERT (First) WILLIAM (Middle) BYNAKER (Last)		4. DATE OF DEATH 5-20-51 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-29-1904 (Month) (Day) (Year)
9. AGE last birthday 46 yrs.		10. If under 1 year: Months 1 Days 19 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Manager		10b. KIND OF BUSINESS OR INDUSTRY Masonic Farm	
11. BIRTHPLACE (State or foreign country) New Market, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WM Bynaker		14. MOTHER'S M maiden name ELIZ. WEAVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Albert Bynaker, Cockeysville, Md.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cardiac failure	
Antecedent cause(s) (b) Rheumatic heart disease	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Calcific aortic stenosis	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Automobile accident	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) Highway
TIME (Month) (Day) (Year) (Hour) 5-29-51 12:10 A	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>
	HOW DID INJURY OCCUR? Operator of car which ran off rd. into telephone pole

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE **William V. Bynaker** (Degree or title) ADDRESS **M.D. 700 Fleet St., Baltimore 2, Maryland** DATE SIGNED **May 29, 1951**

23. BURIAL, CREMATION, or other disposal (Specify) Burial	DATE THEREOF 6-1-51	NAME OF CEMETERY OR CREMATORY St Johns	LOCATION (City, town, or county) Ellicott City, Md.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE May 31 1951 Alice Dr. H. B. Dr.		24. FUNERAL DIRECTOR W. C. Neumann, Ellicott City Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04945

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Columbia Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> STREET ADDRESS (If rural, give location) <u>Columbia Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Elmer Carlton Cavey</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>29</u> (Year) <u>51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-13-1896</u>
9. AGE last birthday <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rosswell Cavey</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Cagle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Isabel B. Cavey, Ellicott City, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

Antecedent cause(s)

(b) Arteriosclerotic Cardio-Vascular disease(c) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

10 minutes3 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.none

19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-1, 1948, to 5-29, 1951, that I last saw the deceased alive on 5-22, 1951, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-1-51</u>	<u>St. Johns</u>	<u>Ellicott City, Md.</u>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 1, 1951</u>	<u>John B. Loughman</u>	<u>F.C. Higinbotham</u>	<u>Ellicott City, Md</u>

Rev. B. E. L.290716

MARGIN RESERVED FOR BINDING

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VS. A15

RECEIVED

JUN 6 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

04946

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>near Ridgeville, Md.</u> LENGTH OF STAY (In this place) <u>1 week</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>109 N. Carey St</u>	
3. NAME OF DECEASED (First) <u>WILBERT</u> (Middle) <u>CARL</u> (Last) <u>COLISON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-29-51</u> 19 <u>51</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Oct 11, 1896</u>		9. AGE last birthday <u>54</u> yrs. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bacteriologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall Kent co</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MARION A. COLISON</u>		14. MOTHER'S MAIDEN NAME <u>JULIA C. RODENHEISER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>219-30-9375</u>	
17. INFORMANT <u>Walter N. Colison</u>		<u>906 W. 38th St</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Thrombosis</u>		<u>instant</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio-Vascular disease</u>		<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION

RMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

04947

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Friendship</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Friendship</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Rachel</u>	(Middle) <u>Ann</u>	(Last) <u>Cook</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 2, 1886</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Barney</u>		14. MOTHER'S MAIDEN NAME <u>Guinea Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Raymond Cook, West Friendship, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary edemaAntecedent cause(s) (b) Arteriosclerotic heart diseaseDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 61

INTERVAL BETWEEN ONSET AND DEATH

1 hour5 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus15 yrs

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to May 3, 1951, that I last saw the deceasedalive on May 3, 1951, and that death occurred at 11:25 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles S. Whitaker, M.D. Clarksville, Md.5/5/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 5, 1951Alice H. HachtWaverly Heights - Clarksville, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04948

Reg. Dist. No. 192

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Cooksville</u> LENGTH OF STAY (in this place) <u>3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Cooksville</u> STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) <u>Vergie</u> (Middle) <u>Maxine</u> (Last) <u>Evans</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>FF.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-27-16</u>
9. AGE last birthday <u>34</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Engene Holtz</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Earnest</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>B.W. Holtz - Sykesville, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

Antecedent cause(s)

(b)

Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 25, 1951, to May 27, 1951, that I last saw the deceased

alive on May 27, 1951, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

SIGNATURE J. W. Holtz (Degree or title) M.D. ADDRESS Sykesville DATE SIGNED 5-28-51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-30-51</u>	<u>Springfield</u>	<u>Sykesville, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 28, 1951</u>	<u>Alice M. Hebr.</u>	<u>Wm. & Haight</u>	<u>Sykesville, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04949

Reg. Dist. No. 191-108

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
TOWN <u>Cooksville</u>		TOWN <u>Cooksville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>WILLIAM</u> (Middle) <u>HENRY</u> (Last) <u>FORSYTHE</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 16, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Circuit Court</u>	9. AGE last birthday <u>77</u> yrs. <input type="checkbox"/> under 1 year <input type="checkbox"/> under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Henry Forsythe</u>		14. MOTHER'S MAIDEN NAME <u>Belle Welling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>M. P. Barrow, SYKESVILLE, MD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			<u>30 Min.</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>			<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at <input type="checkbox"/> Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 17, 1951, to May 17, 1951, that I last saw the deceased alive on May 17, 1951, and that death occurred at 9 55 p.m., from the causes and on the date stated above.

SIGNATURE <u>J. W. Hentzen</u>		DATE SIGNED <u>May 18, 1951</u>	
NAME OF DECEASED <u>M. P.</u>		ADDRESS <u>Sykesville, Md.</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5-19-51</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	LOCATION (City, town, or county) (State) <u>Glenwood, Md.</u>
DATE REC'D BY LOCAL REG. <u>5-19-51</u>	REGISTRAR'S SIGNATURE <u>John B. Longman, Pub. B. & E.</u>	24. FUNERAL DIRECTOR ADDRESS <u>F.C. Higinbotham, Ellicott City, Md.</u>	
<u>E. Pearl Dennis, Ellicott City, Md.</u>			

055936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 6 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04950

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Columbia Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City</u> STREET ADDRESS (If rural, give location) <u>Columbia Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Eudora</u> <u>Giffin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-15-51</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-23-1868</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sykesville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>None</u>	
13. FATHER'S NAME <u>George Hayworth</u>		14. MOTHER'S MAIDEN NAME <u>Emily Berry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Jackson Giffin, Ellicott City, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Arteriosclerotic Cardiovascular disease 5 years

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

nonenone

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5-12, 1951, to 5-15, 1951, that I last saw the deceasedalive on 5-15, 1951, and that death occurred at 11:45 P. a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

George E. Buxton M.D.Ellicott City, Md.5-16-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-18-51</u>	<u>St. Johns</u>	<u>Ellicott City, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>5-17-51</u>	<u>John B. Loughran</u>	<u>F.C. Higinbotham, Ellicott City, Md.</u>		

Pu. B. E. L.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1961
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Howard	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Rockland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Frederick Rd.		STREET ADDRESS (If rural, give location) Old Frederick Rd.	
3. NAME OF DECEASED (First) (Middle) (Last) Mildred K. Grenagle		4. DATE OF DEATH (Month) (Day) (Year) May 24, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 30, 1903--47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Andrew Martin		14. MOTHER'S MAIDEN NAME Anne Healy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 6. Elbert Grenagle, Old Frederick Rd.	
17. INFORMANT AND ADDRESS 6. Elbert Grenagle, Old Frederick Rd.		18. MEDICAL CERTIFICATION Rockland, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-29, 1951, to 5-24, 1951, that I last saw the deceased alive on 5-23, 1951, and that death occurred at 10 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, OR OTHER (Specify) Burial	DATE THEREOF May 28/51	NAME OF CEMETERY OR CREMATORY New Cathedral	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. May 31, 1951	REGISTRAR'S SIGNATURE John B. Loughman	FUNERAL DIRECTOR Harry A. Witzke		
		ADDRESS 4101 Edmondson Ave.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04952

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near Savage, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - near Savage</u>	
TOWN <u>near Savage, Md.</u>		TOWN <u>Rural - near Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>RONALD</u> (Middle) <u>CAMERON</u> (Last) <u>HAYNES</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Dec. 27-1942</u>
9. AGE last birthday <u>8</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolboy</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Elementary school</u>	
12. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. FATHER'S NAME <u>JAMES HAYNES</u>		15. MOTHER'S MAIDEN NAME <u>HAZEL LILLEY</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>-</u>	
18. INFORMANT <u>Miss Hazel Bayen - Savage, Md.</u>		19. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>DROWNING</u>		<u>INSTANT</u>	
(b) Antecedent cause(s) <u>none</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>none</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>LITTLE PATUXANT RIVER</u> (CITY OR TOWN) <u>near Savage</u> (COUNTY) <u>HOWARD</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>14</u> <u>1951</u> <u>4 P.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Nt while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Deceased with 2 playmates near River, fell in river</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>George E. Brugtorf M.D.</u>		DATE SIGNED <u>5-14-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/17/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		LOCATION (City, town, or county) (State) <u>Savage, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5/16/51</u>		24. FUNERAL DIRECTOR <u>Dr. Wm. D. Carroll, Laurel, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 22 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

04953

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 196

1. PLACE OF DEATH- COUNTY <u>Ellicott City Howard Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pinel Clinic, Ellicott City</u>		STREET ADDRESS (If rural, give location) <u>409 Upland Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) (Last) <u>LASKY</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <u>July 4, 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Open?</u>	
13. FATHER'S NAME <u>Harry Lasky</u>		14. MOTHER'S MAIDEN NAME <u>Katie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Marion Friedlander- 409 Upland Rd. Pikesville, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Cirrhosis of liver INTERVAL BETWEEN ONSET AND DEATH 3 mos

Immediate cause

(a)-----

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)-----

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 14, 1951, to May 16, 1951, that I last saw the deceased alive on May 16, 1951, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify)	DATE THEREOF <u>5/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cong.</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
--	--------------------------------	---	--	---------

DATE REC'D BY LOCAL REG. <u>5-12-51</u>	REGISTRAR'S SIGNATURE <u>L</u>	24 FUNERAL DIRECTOR <u>Sol. Levinson + Bros - 1124-26 W. North</u>	ADDRESS <u>290836 Avenue</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04954

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Elkridge (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 112 Montgomery Rd</u>		STREET ADDRESS (If rural, give location) <u>Box 112 Montgomery Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Alexander</u>	(Middle) <u>A.</u>	(Last) <u>Mars</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>25</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 10 1874</u>
9. AGE last birthday <u>81</u> yrs.	If under 1 year	If under 24 hrs.	If under 1 year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gardener</u>	11. BIRTHPLACE (State or foreign country) <u>Elkridge Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alexander Mars</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Oliver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Laura Mars, (Daughter) Elkridge</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) BronchopneumoniaINTERVAL BETWEEN ONSET AND DEATH 4 da

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocardial infarction(c) Essential ArteriosclerosisII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION none19b. MAJOR FINDINGS OF OPERATION Senility

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 21, 1951, to May 21, 1951, that I last saw the deceasedalive on May 25, 1951, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/28/1951</u>	<u>Gaines Cem.</u>	<u>Elkridge</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/28/51</u>	<u>A W Hedgcock</u>	<u>Mrs Katie R. Williams</u>	<u>Schneider St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100/105

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04955

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Clarksville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rebecca Cissel Simpson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-27-51</u> 19 <u>51</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>10-7-1859</u>
9. AGE last birthday <u>91</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>James Cissel</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Stockdale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Laura Simpson, Clarksville, Md</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Chronic myocardial failure</u>			<u>4 days</u>
Antecedent cause(s) (b) <u>arteriosclerotic heart disease with auricular fibrillation</u>			<u>5 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>cerebral hemorrhage c left hemiplegia</u>			<u>6 months</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/2</u> , 19 <u>50</u> , to <u>5/27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>51</u> , and that death occurred at <u>4:00 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Charles S. Whitaker, M.D.</u>		ADDRESS <u>Clarksville, Md.</u>	DATE SIGNED <u>5/30/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-30-51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	LOCATION (City, town, or county) (State) <u>Highland</u>
DATE REC'D BY LOCAL REG. <u>5/31/51</u>	REGISTRAR'S SIGNATURE <u>Mari A. Whitaker</u>	24. FUNERAL DIRECTOR ADDRESS <u>F.C. Higinbotham, Ellicott City, Md.</u>	

MARGIN RESERVED FOR BINDING

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RECEIVED
JUN 4 1951
BUREAU V. S.